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ON AMPUTATION AT THE HIP-JOINT.

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Since the late war a radical change has taken place in the operation of amputation at the hip-joint under certain conditions. In the wars of Napoleon I, Baron Larrey performed the operation six times, with a mortality of five cases. For many years many of his distinguished surgical successors met with no better success. From such unhappy results it was considered by many a criminal practice to perform this operation.

Under this state of discouragement I was called upon to perform the operation in 1861 on a lad, seventeen years of age, who had an extensive strumous necrosis of the femur. I had hesitated to operate for a year or more, but the patient's suffering was so great that it was about his daily cry that I should "cut his leg off." Finally I submitted the case to able medical counsel, and under their approval, more than my own, I performed the operation. Having but little confidence in any of the usual flap operations, and as life is jeopardized in the ratio of their nearness to the abdomen, I thought of a plan that seemed to me would act more favorably. The authorities on hand made the amputation at the upper thigh, 1 in 7 prove fatal; in the excision of the hip-joint, 1 in 15 proved fatal. Taking the three operations into consideration, that is, including amputation at the hip-joint, what can be more conclusive than that the flap tends greatly to a fatal shock and septicemia. With these facts before me, I submitted my patient to the double operation of (circular) amputation of the upper thigh, followed immediately by excision of the remaining femur out of the joint. To effect this expeditiously I had instruments constructed expressly for the case: as the "flexible knife," made out of a watch-spring, to cut the upper femur out of the periosteum, and a holder to transfix the bone while this part of the operation was performed, etc. The operation was enforced with facility, and the following are the advantages we thought in favor of this method of amputating at the hip-joint over the usual methods:

1. It removes the wound from the body, and thereby lessens *a priori* the tendency to mortality.
2. It is performed with less loss of blood.
3. The shock is not likely to be so great.
4. The surface of the wound is less.



5. The flaps (if such they can be considered) are shorter and more massive, and therefore tend less to sloughing.

6. A sufficient stump may be secured for the adjustment of an artificial leg.

7. Owing to the remarkably close dissection that takes place by using the flexible knife in cutting the bone out of a hypertrophic periosteum, may we not retain the physiological function of that membrane so as, in course of time, even to give osseous or cartilaginous consistency to the stump?

Unfortunately we finally lost our patient through secondary hemorrhage.

The operation was performed in the presence of an able corps of surgeons and physicians, and reported in the *Boston Medical and Surgical Journal*, vol. lxvi, and referred to by the Surgeon-General in his Special Circular No. 7, On Amputation at the Hip-joint.

The object I have in referring to this case at this late day is to establish my priority in causing an important change in performing this formidable operation; and why in my "Medical Consultation Book," in the list of "Proper Names in Medicine," I affixed my name to the operation. The report of the case drew special attention in the surgical centers of Europe, and was performed with modifications in several hospitals, but from the reports usually given as original operations. After the operation was accepted in this country, credit of it was dealt out in details to every operator, particularly when the operation was performed with success. In the late war, in the U. S. Army, the operation was performed seven times with success, cases reported as "Re-amputation at the Hip-joint." Since the war, in civil practice, the operation in this and European countries has been repeatedly performed with success.

While in winter quarters, 1862-3, at Buckhannon, W. Va., I was summoned to the home of Sergeant Phillips of the First Virginia Infantry, about twenty miles through a guerilla-infested country. Amputation at the hip-joint was the operation indicated. He was suffering from a gunshot wound; the ball passed through Scarpa's triangle, fracturing the left femur close below the trochanters. He had been wounded nine months before I saw him, and in the military hospital was considered a hopeless case. I found him very much reduced, with a thigh enormously distended and fistulated at several places. I concluded not to amputate, but made a bold and extensive dissection in hunt for the ball,

which was the source of all the mischief. I found it partly imbedded in an ossified formation between the fractured ends of the bone. I broke two bullet forceps in the attempt to dislodge it, and was now left helpless without the necessary instruments to prosecute further the operation. At the same time the patient was alarmingly affected by the chloroform. At this critical moment I quickly placed my knee under his thigh, and with a quick, heavy blow on his knee caused a surgical fracture of the thigh at the weak point where the ball was lodged. I was now able to pick out the ball, which was in two parts, with all the necrosed spiculæ, with my fingers. Under the care of a local physician, who assisted me in the operation, the patient finally recovered, with a leg about four inches too short. He was for many years a pensioner, and I am not aware but he is still living.

This was the most formidable surgical operation in my experience. But when the Surgeon-General called for reports of surgical operations of the war for the Medical and Surgical History of the Rebellion, while accepting others that I reported, this one he would not accept, or it was overlooked.

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